ADATSA TREATMENT ELIGIBILITY

CLIENT'S NAME

SECTION 9 INCAPACITY

Indicate each criteria that is met:

- ☐ Current pregnancy or within two months postpartum
- ☐ At least meets criteria for substance abuse and referred by Child Protective Services (CPS)
- ☐ Severely dependent and current intravenous (I.V.) drug user
- ☐ Severely dependent and at least one prior admission to department-approved alcohol/drug treatment or detox program
- ☐ Severely dependent and two or more arrests for alcohol/drug related offenses
- ☐ Lost two or more jobs within past six months due to chemical dependency

SECTION 10 SUMMARY OF TREATMENT ELIGIBILITY

ALL QUESTIONS BELOW MUST BE ANSWERED "YES" FOR THE APPLICANT TO QUALIFY FOR ADATSA TREATMENT.

	YES	NO
1. Is the client substance dependent, for a class of substances other than nicotine or caffeine, as identified in Section VII?	☐	☐
2. Is the client incapacitated by at least one of the criteria specified in Section VII?	☐	☐
3. Has the client used alcohol or other drugs within the last 90 days (excluding incarceration)?	☐	☐
4. Has the client been unemployed for at least the last 30 days?	☐	☐
5. Is the client amenable to treatment?	☐	☐
6. Is the client willing to accept treatment?	☐	☐
7. Is the client not choosing opiate dependency treatment (methadone maintenance) only?	☐	☐

SECTION 11 ADATSA ELIGIBILITY DETERMINATION

1. ADATSA eligibility: ☐ **Yes** ☐ **No**

2. REASON FOR EXCLUSION

☐ Not chemically dependent ☐ Not willing to accept treatment ☐ Not amenable to treatment
☐ Not used in last 90 days ☐ Not incapacitated ☐ Chose OMT only
☐ Employed in last 30 days

3. TREATMENT PRIORITY (CHECK ONE BOX ONLY)

☐ No priority/not applicable ☐ IV Drug User ☐ Children in the home
☐ Child Protective Services ☐ Pregnant

4. OTHER INCAPACITY

☐ No other incapacity ☐ Mental Health ☐ Physical incapacity ☐ Physical and mental incapacity

SECTION 12 ASSESSMENT COMPLETION

FORWARD REFERRAL (CHECK ALL THAT APPLY)

☐ Detoxification ☐ ADATSA treatment ☐ Non-ADATSA treatment
☐ Self help group ☐ ADIS ☐ ADATSA assessment center
☐ Medical/dental services ☐ Mental health services ☐ CD involuntary commitment
☐ Other: ☐ **No referral**

SECTION 13 FUNDING SOURCE

1. ASSESSMENT CONTRACT TYPE IS ADATSA

2.A. COUNTY SPECIAL PROJECT	2.B. STATE SPECIAL PROJECT	2.C. AGENCY SPECIAL PROJECT

3. ASSESSMENT FUNDING SOURCE (CHECK ONE)
☐ County Community Services ☐ Tribal Community Services

4. TITLE XIX	5. GOVERNING COUNTY (IF NOT COUNTY AGENCY)	6. ASSESSMENT STAFF ID	7. CASE MONITOR'S NAME (IF DIFFERENT)
☐ Yes ☐ No			

8. ASSESSMENT DURATION	9. INTERVIEWER'S SIGNATURE	DATE
hours minutes		

I was informed of the results of this assessment, recommendations, and my right to be referred to any approved agency offering services consistent with the results of this assessment. Further, I was informed that treatment funded by ADATSA is limited to providers who are authorized to provide services by the Division of Alcohol and Substance Abuse. I have also been informed that it is the policy of the Assessing Center that no person shall be subjected to discrimination because of race, color, national origin, sex, age, religion, creed, marital status, sexual preference, HIV/AIDS status, disabled veteran status, Vietnam Era veteran status, or the presence of any physical, mental, or sensory disability, or place of residence.

4. COUNSELOR'S SIGNATURE	DATE	5. CLIENT'S SIGNATURE	DATE